Linda Becker, B.S., L.M.T.

Client Intake Form

Name _____

Address_____

City _____State _____ Zip _____

Home: _____ Work: _____ Cell: _____

Email: _____

Height: _____ Weight: _____ Birth Date: _____

Profession _____

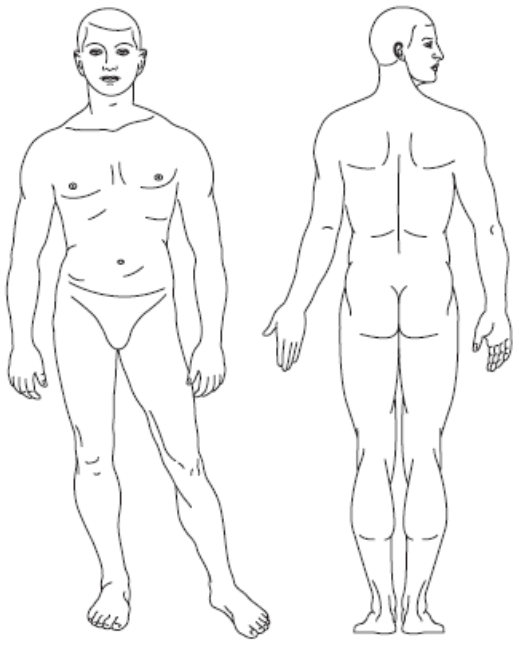
Referred by _____

Physician's Name / Phone_____

Health History (check one box per item)

	Currently	Past	No		Currently	Past	No
Contact Lenses				Allergies			
Dentures				Varicose Veins			
Headaches				Phlebitis/Blood clots			
Neck Pain				Heart Problems			
Shoulder Pain				High/Low Blood Pressure			
Back Pain/Sciatica				Ulcers			
Spinal Problems				Tendonitis/Bursitis			
Knee Problems				Arthritis or joint disease			
Ankle Problems				Diabetes			
Foot Problems				Seizures/Convulsions			
Osteoporosis				Multiple Sclerosis			
Broken Bones				Nerve degeneration			
Easy Bruising				Cancer or tumors			
Skin Problems				Infectious diseases			

Please mark any areas of pain or concern:



Any surgeries or other medical condition(s) the therapist should be aware of?

_____

_____

_____

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health. I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified physician for any physical ailments that I have. I understand that massage therapy is a therapeutic health aide and is non-sexual. I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signature: _____ Date: _____

Printed: _____ For Self or Minor? Self Minor